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The WHO's claim that COVID wasn't airborne cost millions of lives. Now, they're changing the definition of airborne.

The story of how incorrect science became the basis of the global COVID response is the biggest scandal you never heard about.

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The WHO is patting itself on the back this week.

After two years of argument and discussion, it has officially rebranded airborne viral transmission as “through the air” transmission. Airborne particles aren’t aerosol anymore; they’re “Infectious Respiratory Particles,” or IRPs. Jargony language aside, the major practical implications of this document are that, unlike previous airborne infection control guidance, their new guidance will not, in fact, control airborne infections.

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2020, they tweeted a famous and famously still-not-deleted fact check proclaiming this loud and clear. "FACT: #COVID19 is NOT airborne. The #coronavirus is mainly transmitted through droplets generated when an infected person coughs, sneezes or speaks," the tweet reads, going on to recommend disinfecting surfaces, staying 1m distance from others, washing hands, and not touching your face. It's accompanied by a graphic that looks like it was made in 20 minutes by an unpaid intern, which again affirms that COVID IS NOT AIRBORNE. All of the information in this short tweet is incorrect.

It also informed the global COVID response from top to bottom, making elimination of the virus impossible as governments implemented an inadequate protocol for stopping the spread.

From the beginning, the WHO was promoting a now-disproven model of infectious disease control centered on an artificial distinction between diseases transmitted by "droplets" - meaning large particles emitted while coughing and sneezing which quickly fall to the ground- and "aerosols" - meaning smaller particles that are emitted simply by breathing that can hang in the air like smoke. The best layman's summary of the droplet vs. airborne scandal can be read here, in Megan Molteni's thorough piece "The 60-Year-Old Scientific Screwup That Helped Covid Kill", published at *Wired* in May of 2021.

Molteni's piece follows a small group of intrepid scientists- Linsey Marr, an aerosol expert, Lidia Morawska, an atmospheric physicist, Yuguo Li, an indoor air researcher at the University of Hong Kong, and Katie Randall, an infectious disease historian, as they attempt to convince the WHO and other health institutions to take airborne spread of COVID seriously. In the process, they dig into the deep roots of scientific misinformation that led to the creation of the droplet vs. airborne dichotomy; incredibly, there was *never* any strong evidence to indicate that most viruses were spread via heavy "droplets" that fall to the ground. It was quite simply a creation of convenience predicated on poor assumptions, misinterpretations, and conflations. I recommend reading the whole piece, but in essence, institutions have been believing what they wanted to believe about airborne transmission for a long time.

It should also be noted that the institutional and financial motivations for failing to acknowledge airborne transmission of COVID and other viruses are pretty

straightforward; it is, quite simply, far more expensive to implement proper infection control protocol for a virus that spreads through the air because a human is breathing than it is to implement infection control protocol for a virus that spreads when someone sneezes on you.

This paper, titled "Coronavirus Disease 2019 and Airborne Transmission: Science Rejected, Lives Lost. Can Society Do Better?" and co-authored by Morawska, provides an inside look at the WHO's refusal to contend with scientific evidence, their allergy to all discussion of airborne transmission, and their dismissive, rude and stubborn behavior as aerosol experts came together to try and correct their incorrect guidance as COVID gained ground. "We alerted the World Health Organization about the potential significance of the airborne transmission of SARS-CoV-2 and the urgent need to control it, but our concerns were dismissed," affirm the authors, going on to discuss their formation of the so-called Group 36:

> On 29 March [2020], Morawska drafted a message in the form of a petition to the WHO director general (DG) and compiled a list of experts—colleagues of high international standing from around the world—whom she knew had been working on airborne transmission for many years from various angles, including aerosol physics, virology, public health, clinical medicine, infection prevention and control, building engineering, and facility management. She had worked on this broad topic over the years with several of these individuals. The next day she contacted all of the identified experts, explaining the problem, presenting the draft, and asking if they would like to support the petition. Every one of them did so, and some suggested names of additional experts to include. The list expanded to 36 names, a sizable group; although we knew that many more experts could have been enlisted given more time this was a manageable group who represented a breadth of expertise from around the world. This is how "Group 36" was born.

The WHO did not respond well to this petition, which again, was signed by the foremost experts in airborne transmission. Multiple meetings yielded nothing but irritated dismissal on the part of WHO, with participants recalling:

> We were backed into a defensive position during the call, while we tried to make our points. After the call was finished, disappointed and frustrated, we wondered, Why

> are they acting like this? Why are they so bluntly rejecting our arguments?

Email correspondence between the two groups- the WHO and the aerosol expert petitioners- is attached to the paper. The correspondence shows that the WHO either failed to grasp or represented themselves as failing to grasp the points made by the aerosol experts. Multiple times, they repeat false claims about how sure they are that COVID is spread via "droplets", that respirator-style masks only need to be worn during AGPs (aerosol-generating procedures, an incorrect claim that is still repeated by medical practitioners today), and that fomites are a significant source of COVID transmission (they are not). They also repeatedly make arguments from authority, pointing to individuals who agree with them while refusing to engage with the science itself. In one impressive piece of circular logic in an email dated April 11, 2020, the WHO states:

> To our knowledge and after careful review, available evidence on SARS-CoV-2 supports that the predominant route of human-to-human transmission of this virus is through respiratory droplets and/or contact routes. We note that also guidance from CDC, ECDC, and many other organizations all state that the mode of transmission of COVID-19 is primarily respiratory droplets and contact.

In this excerpt, the WHO cites the guidance of other organizations which are turn following WHO guidance. They cite no studies to shore up their claims that COVID must be spread via droplets, but sneeringly point out that the aerosol scientists have not produced "peer reviewed" studies demonstrating airborne spread. In April 2020, of course, it was impossible for any peer review to have been completed concerning a virus that was then a few months old.

Throughout the debate between the powerful WHO players and the upstart aerosol experts, the threshold of "proof" for airborne spread was unreachably high, while the threshold of "proof" for droplet spread was nothing at all. WHO continually states that they *know* COVID is spread via droplets while failing to address any of the actual scientific content of the petition from Group 36.

The work of these scientists, along with dozens of others, led to the groundbreaking realization that *all* common respiratory viruses- colds, flus, RSV, etc- are being spread in

a manner that would have formerly fallen on the "airborne" side of the false airborne/droplet dichotomy. Hence the need to rethink the terminology entirely- and common infection control practices.

Once this was established, we stood at the precipice of a new era of disease control; imagine a clean air revolution in daycares, drastically cutting down the now-spiking rate of childhood illness. But three years after Molteni's rundown was published, most medical institutions and government bodies are still practicing and recommending droplet infection control measures for COVID. What happened?

First, there's been a lack of consistent, public communication. Today, most of the public still uses the mental model of "droplet" spread to understand COVID transmission- and that includes doctors and administrators in medical settings. Measures like social distancing, handwashing, wiping surfaces, and wearing surgical masks (not respirator style masks that form a seal) are insufficient to control the spread of COVID-19; some of them are out-and-out pointless. While things like surgical masks and distancing do reduce likelihood of transmission somewhat- not entirely- fomite transmission of COVID has never been documented and surface disinfection is wholly irrelevant to spread.

The failure to loudly communicate that our global health organizations were devastatingly wrong about something they stated with a high degree of confidence is perhaps unsurprising. That their claims led to 20-30 million deaths and counting, all the more so. In order to correct all the misinformation that the public, doctors, hospital administrators, health bodies and public officials absorbed during the full-court press to mitigate COVID with insufficient droplet measures, the WHO would need to loudly and publicly repeat that all their prior guidance was wrong. Not only that, but it was wrong because they *lied*; it's true that they seem to have really believed their own misinformation, and in that sense, they approached the conversation honestly. But it was a *lie* to say they had *proof*, that they knew *beyond a doubt,* that COVID was not airborne.

Take WHO's new Chief Scientist Jeremy Farrar's comments this week, for example. He states:

> In January, in February, in March, in April of 2020, the certainty of the scientific evidence compared to six months later, a year later, now, four years later, April 2024, is completely different.

In his defense of the WHO's declaration that COVID was not airborne, he is here pointing out that the scientific evidence was *uncertain*. That's true; it's also why it was so irresponsible to present the claim "COVID is not airborne" with a *high degree of certainty.* A responsible body would have said "we are debating this, we don't know, and the precautionary principle dictates that we should implement airborne infection control until we do." Instead, they tweeted a graphic with a big INCORRECT stamp over the correct statement "COVID is airborne." Not the language of an uncertain body communicating uncertain science.

The WHO, rather than demonstrate humility and contrition in the face of a world-circling failure that sent us down an infection control dead-end, continues to double down on excusing itself. That brings us to their newest attempt to both exculpate themselves and give governments and medical practitioners all over the world license to continue refusing to implement airborne infection control, endangering patients and citizens: this dry-sounding document, "Global technical consultation report on proposed terminology for pathogens that transmit through the air."

Not everything in the document is terrible. On the plus side, the WHO finally invited subject matter experts like Linsey Marr to the table. They also were correct to eliminate the false dichotomy between airborne and droplet spread; as it turns out, viruses that spread via respiratory particles are contained in both large droplets and smaller aerosolized particles that can travel far beyond the arbitrary 6-feet range of the social distancing era. But this is where the positives end.

Instead of finally acknowledging that, since all these aerosolized viruses can spread in a manner consistent with what was formerly called "airborne" transmission, "airborne" infection control measures are required to control them, the WHO attempts to have its cake and eat it too by simply reimagining what infection control is supposed to accomplish. Instead of ensuring that patients will not be exposed to viruses in medical settings, the WHO is now encouraging medical practitioners to simply follow their

hearts when it comes to the spread of COVID and other viruses. Is it an airborne "vibe"? Is it more of a "droplet" vibe? Whichever suits, take your pick!

From their paper:

> There is NO suggestion from this consultative process that to mitigate the risk of short-range airborne transmission full 'airborne precautions' (as they are currently known) should be used in all settings, for all pathogens, and by persons with any infection and disease risk levels where this mode of transmission is known or suspected. But conversely, some situations will require 'airborne precautions'. This would clearly be inappropriate within a risk-based infection prevention approach where the balance of risks, including disease incidence, severity, individual and population immunity and many other factors, need to be considered, inclusive of legal, logistic, operational and financial consequences that have global implications regarding equity and access.

This word salad essentially means "yeah, all these viruses can spread via airborne transmission, but since airborne precautions are annoying and expensive, you don't really have to do them". It provides legal and institutional cover for the medical bodies who are still refusing to acknowledge airborne spread of COVID-19 and implement proper infection control. Vague terms like "balance of risk," "severity," "individual and population immunity," all leave open an incredibly dangerous window for continued spread of COVID in medical settings; especially as one man's "mild" is, quite literally, another man's "severe".

The terms "severity" and "population immunity" serve as a dog whistle to let government bodies and medical institutions know, yes, we did finally have to acknowledge that COVID is airborne. But *don't worry,* this doesn't mean we're actually going to make you do airborne infection control. If you think it's okay for your patients to contract COVID, it's a-ok by us too! "Immunity" in particular is a highly-abused term in the context of COVID; most people achieve a temporary immunity from vaccination and/or infection, which rapidly fades. In an effort to normalize continual reinfection, our governments began conflating this short-term, rapidly fading protection that varies from person to person with the lifelong protection formerly known as "immunity", a term which better applies to diseases like measles or chickenpox. *Herd* or *population*

immunity in the context of measles means vulnerable people are *never* exposed to measles. Herd immunity in the context of COVID means vulnerable people are *constantly* exposed to COVID. It's all very "war is peace."

A note on the claim that "equity" and "access" are the true motivators behind the WHO's poor guidance. Here, the body is attempting to argue that, because poor countries cannot afford proper airborne infection control, no one should have access to proper airborne infection control; hooray, that's equity! Aside from the patent ridiculousness of this argument, let's compare this with claims the WHO made four years ago vis-a-vis the same topic, while still claiming that airborne spread wasn't happening.

Email from WHO Health Operations, Infection Prevention and Control Technical Team to Group 36, April 11, 2020:

> The basis for the content of WHO guidance is as follows:
>
> 1) current evidence on SARS-CoV-2 predominant modes of transmission and lessons learned from the evidence on SARS, MERS and other respiratory viral infections;
>
> 2) direct experience with COVID-19 patients by frontline workers, epidemiologists, virologists and other scientists;
>
> 3) input, discussions and consensus by a large group of international independent experts in the fields of infectious diseases, epidemiology, public health and infection prevention and control, with special focus on viral respiratory infection (captured through our COVID-19 global expert network teleconferences);
>
> 4) global perspective including equity, ethical, and implementation considerations of WHO guidelines.
>
> The latter is important for a global organization that needs to take into consideration capacity across health systems in different countries; however, **under no circumstances does this aspect overcome available evidence.** WHO is always reviewing available evidence and will adapt guidance based on this evidence – as always done for all infectious hazards. COVID-19 is no different. **Would there be**

> **evidence of significant spread of SARS-CoV-2 as an airborne pathogen outside of the context of AGPs, WHO would immediately revise its guidance and extend the recommendation of airborne precautions accordingly despite the known limited capacity to apply them in all countries, in particular in low- and middle-income countries.**

Emphasis mine. There, in black and white, the WHO contradicts its new guidance, stating in no uncertain terms that if COVID were airborne (it is), airborne infection control measures *should be and would be recommended*, even given the difficulties and expense of instituting such protocols.

Proper infection control guidance should do one basic thing: *ensure that infections are controlled.* Ensure that patients are not needlessly exposed to viruses- of any kind- while seeking medical care. The revolutionary progress we've made in understanding the behavior of viruses over the past several years, coupled with the fantastic technology that already exists to clean the air, would mean a much healthier society if that progress were applied practically. Instead, we're becoming a much sicker society as the WHO sinks further into denial.

This document exists to handhold a small group of elite scientists who were incredibly, undeniably, dangerously wrong, and allow them to continue pushing their failed model of "infection control" which does not, in fact, control infections. It exists to assuage their damaged and bruised egos while assuring them they weren't wrong to tell people to stand six feet apart and wipe down surfaces and cover their sneezes; this is, after all, the most practical and feasible form of infection control to implement even if it turns out the virus itself maybe, kind of, sort of, spreads in a completely different way.

The damage of the WHO's false claims continue to reverberate today. Doctors and hospitals continue to infect their patients with flu, RSV, strep, and now COVID as infection control measures like HEPA filtration go completely unmentioned in the new guidance document. Hospitals continue to place highly infectious patients close to COVID-negative patients, falsely believing that curtains and a few feet of distance will protect vulnerable sick people. Doctors and nurses continue to lack proper PPE, while acquiring Long COVID at high rates and dealing with out-of-control hospital crowded all over the world. And perhaps most damaging at all, the public has been lulled into a

sense of complacency and encouraged to believe that COVID simply cannot be controlled. Unaware that the protocols implemented in 2020 were plainly incorrect for mitigation and elimination, the defeatist refrain rings out everywhere, “COVID is here to stay, there’s nothing we can do.”

The WHO has a responsibility to engage seriously with the science of airborne infection control and make recommendations that minimize the spread airborne disease- not recommendations that seek instead to minimize its own embarrassment and responsibility.

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